bones which rarely is permanent. A return to work should not be made while the swelling persists. (4) The pathology has never been directly studied, but theoretically there is a diffuse, fibrous exudation under the skin, which is either slowly absorbed or becomes organized. (5) The differential diagnosis from the œdema of inflammation is easy, as the latter is soft and red, with a wound at the point of infection and involvement of the neighboring lymph glands. The differentiation from œdema, due to disturbed circulation as the result of pressure, is also a simple matter. Fracture of the metacarpal bones gives more localized symptoms with ecchymosis, the duration of the swelling is shorter, union is followed by deformity due to callus formation, and an X-ray examination makes the diagnosis positive. Hemorrhage is followed by ecchymoses, which are always absent in traumatic œdema. As a rule, the diagnosis is easy, but it can become a matter of difficulty when the hard and diffuse œdema lasts a long while, or when it becomes localized over a metacarpal bone. In all cases one should remember the traumatic origin of the disease, and not confuse it with a chronic inflammation, such as tuberculosis. (6) The treatment should consist of warm baths. Massage has proven more harmful than beneficial, and pressure bandages proved to be perfectly useless.

Extradural Hemorrhage from Rupture of the Middle Meningeal Artery.—JOPSON (*Annals of Surgery*, March, 1903) reports in detail three cases. In the last one the symptoms closely simulated those of extradural hemorrhage, but which operation showed it to be absent. In the first case the line of fracture crossed the anterior branch of the artery and explained its laceration. In the second case there was no fracture; the contusion was sufficient to rupture the vessel, a possibility well recognized. As regards the symptomatology of these cases, in the first one the classical clinical picture of extradural hemorrhage was absent, the symptoms being more those of fractures of the skull, with concussion or injury of the brain. The leakage of blood through the fissure into the subaponeurotic space probably relieved the pressure on the brain for a time and accounted for the preservation of consciousness and absence of paralysis. The temperature, slightly subnormal at first, then moderately elevated, was most suggestive of hemorrhage. The slow pulse is not always observed with epidural clot, but in this case the sudden drop to 48 before operation was significant of cerebral compression. In the second case the clinical picture was most complete. The initial stunning, the interval of consciousness followed by rapidly deepening coma, with subnormal temperature, slow pulse, stertorous breathing and contralateral hemiplegia, with dilatation of the pupil on the affected side, made up a symptom complex which scarcely admitted of other interpretation. In the last case the diagnosis of hemorrhage, while less certain, was justifiable, and trephining strongly indicated. There was a history of loss of consciousness, followed by its partial restoration, and then in a short time a deepening coma, with severe convulsions, starting on the opposite side from the injury, and followed by paralysis of the face on that side. The exact nature of the lesion remains unknown, but it seems probable that there was a slight hemorrhage or laceration in the motor area. The measurement used for locating the trephine openings and exposing the anterior branch of the artery in the last two cases—two finger-breadths behind the external angular process of the frontal bone and three finger-breadths above the zygoma—corresponds very closely to the measurement formerly recommended by Treves, viz., one and one-half inches behind the external angular process of the frontal bone, and one and three-quarter inches above the zygoma. Treves now recommends a point located on a line drawn through the supra orbital ridge parallel to Reid's base line at a point from 3 to 4 cm. behind the external angular process. Pluminet has found all the measurements recommended for exposing the posterior branch to be unreliable, but Steiner's as open to the least objection. This locates it at a point where a line drawn horizontally through the glabella is intersected by a vertical line running just in front of the mastoid process.

The Technique of Lavage of the Stomach.—NECK (*Centralblatt für Chirurgie*, December 27, 1902) states that in washing out the stomach the question at this time is the danger attending the outflow or siphonage of the contents. The usual procedure consists in the introduction of a tube into the stomach; then the fluid is poured into the stomach through this tube, and then siphoned off again. In many cases this flowing out goes on easily, and apparently all of the fluid introduced comes away, but sometimes there are difficulties. Occasionally it is quite impossible to get all of the fluid to flow out of the stomach, even though a large amount of solution be put in. Even moving the tube about and the consequent straining on the part of the patient fail to empty the stomach. Such difficulty is often encountered in the cases where there is a motor insufficiency of the organ, especially when complicated by gastrectasis and pyloric stenosis. The question of completely emptying the stomach of its contents is an important one before operating upon that organ, as any fluid that may be present at the time the stomach is opened only tends to complicate the operation. In order to avoid this complication the author has endeavored to find a safe and easy method by which the stomach may be completely emptied of its contents. In the usual way of practising lavage the patient is placed in a horizontal position, or else remains sitting up. The author states that he believes in retaining either of these positions only as long as the siphonage goes on freely, and then the patient should be placed in the full pelvic position, and this will be followed in nearly every case by a return of the flow. The tube should then be slowly withdrawn (while the patient remains in this position), and as it comes out the last of the stomach contents will be withdrawn In each case in which this method was practised the stomach was found to be completely empty at the time of operation. The author has also experimented extensively on the cadaver with this method, and in each instance with great success. In conclusion he states that in those cases where the stomach is filled with particles of food the lavage must be repeated several times before the organ is empty.

The Diagnosis of Intestinal Injury following Abdominal Contusion.—LE CONTE (*Annals of Surgery*, April, 1903), after giving the history and treatment of thirteen cases, states in conclusion: First. That a moderately assured diagnosis of grave injury must be made before operation is undertaken, or one will open many abdomens to find the trauma confined to the